SERFF Tracking Number:	*UHLC-126575306*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*45371*
Company Tracking Number:	*S931436AGWBAR01 01B*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*MIPPA Web Enrollment Application/S93143AGWBAR01 01B*		

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: Medicare Supplement	SERFF Tr Num: UHLC-126575306	State: Arkansas
TOI: MS08G Group Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Filed-Closed	State Tr Num: 45371
Sub-TOI: MS08G.001 Plan A 2010	Co Tr Num: S931436AGWBAR01 01B	State Status: Filed-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Author: Tammy Frederick	Disposition Date: 04/09/2010
	Date Submitted: 04/07/2010	Disposition Status: Filed-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: MIPPA Web Enrollment Application
Project Number: S93143AGWBAR01 01B
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 04/09/2010

Deemer Date:
Submitted By: Tammy Frederick

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Association
Explanation for Other Group Market Type:
State Status Changed: 04/09/2010
Created By: Tammy Frederick
Corresponding Filing Tracking Number: S931436AGWBAR01 01B

Filing Description:
UnitedHealthcare Insurance Company
NAIC No. 0707–79413
Group Accident and Health Insurance

RE: United HealthCare Insurance Company
AARP Medicare Supplement/Select Advertising Material
MIPPA Web Enrollment Application

SERFF Tracking Number:	*UHLC-126575306*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*45371*
Company Tracking Number:	*S931436AGWBAR01 01B*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*MIPPA Web Enrollment Application/S93143AGWBAR01 01B*		

NAIC No: 0707-79413
File No: S931436AGWBAR01 01B (PLEASE USE THIS NUMBER IN ALL CORRESPONDENCE)

We enclose for your information, proof copies of an enrollment application for use in connection with the AARP group health insurance program. The enclosed enrollment application is new and does not replace any material previously submitted to the Department. The enclosed form will be used with Mass Media Marketing.

The definitions, disclosures, eligibility requirements, exclusions, limitations, Group Policy Form No. GRP 79171 GPS-1, as well as, the statement, "…not connected with, or endorsed by, the U.S. Government or the federal Medicare program," can be found in GU25003AR which was approved by your Department on 11/3/09 under State Tracking Number 43646.

The attached list of enclosures indicates the contents of each package including the form number, and title of each item.

We trust the enclosed forms are in order and look forward to your prompt acknowledgment of this filing. If you have any further questions you can contact me at 215/902-8444. If you prefer, you may also send a facsimile to me at Fax: 215/902-8813 or send an email to Susan_J_Cipollo@uhc.com.

Sincerely,

Susan J. Cipollo
Director, Marketing Compliance

SJC:tmf
Enclosures

List of Enclosures
Medicare Select
MIPPA Web Enrollment Application

S931436AGWBAR01 01B – Web Enrollment Application

SERFF Tracking Number:	*UHLC-126575306*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*45371*
Company Tracking Number:	*S931436AGWBAR01 01B*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*MIPPA Web Enrollment Application/S93143AGWBAR01 01B*		

Approved 11/5/09 under St. Tr # 43459

Standardized Medicare Supplement Certificates: MDA 0001 – MDN 0007 (Mass Marketed)
Standardized Medicare Supplement Certificates: MAA 0010 – MAN 0016 (Agent Sales only)
Standardized Medicare Select Certificate: MDSC 0008, MDSF 0009 (Mass Marketed)
Standardized Medicare Select Certificate: MASC 0017, MASF 0018 (Agent Sales only)
Plan Benefit Tables: BT25 – BT33
BT002 ST AB, CF, KLN
BT002 ST CCSelect,
BT002 ST FFSelect
Plan Overviews: POV3, POV4
Rules & Disclosures: RD4, RD5
Premium Rate Pages: MRP0001 (Med Supp), MRP0002 (Med Select) - - (All Non-Agent Marketing Channels)
MRP0003 (Med Supp), MRP0004 (Med Select) - - (All Marketing Channels)
Medicare Select Plan of Operation: PO3

Company and Contact

Filing Contact Information

Susan Cipollo, Director
680 Blair Mill Rd.
Horsham, PA 19044
Susan_J_Cipollo@uhc.com
215-902-8444 [Phone]
215-902-8813 [FAX]

Filing Company Information

UnitedHealthcare Insurance Company
450 Columbus Boulevard
PO Box 150450
Hartford, CT 06115-0450
(860) 702-5000 ext. [Phone]

CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No

SERFF Tracking Number:	*UHLC-126575306*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*45371*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
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Project Name/Number:	*MIPPA Web Enrollment Application/S93143AGWBAR01 01B*		
Fee Explanation:	per form - 1 form		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	$50.00	04/07/2010	35460705

SERFF Tracking Number:	*UHLC-126575306*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*45371*
Company Tracking Number:	*S931436AGWBAR01 01B*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*MIPPA Web Enrollment Application/S93143AGWBAR01 01B*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed-Closed	Stephanie Fowler	04/09/2010	04/09/2010

SERFF Tracking Number:	*UHLC-126575306*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*45371*
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Project Name/Number:	*MIPPA Web Enrollment Application/S93143AGWBAR01 01B*		

Disposition

Disposition Date: 04/09/2010
Implementation Date:
Status: Filed-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126575306*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*45371*
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Project Name/Number:	*MIPPA Web Enrollment Application/S93143AGWBAR01 01B*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Filed	Yes
Supporting Document	Application	Filed	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	WEB Enrollment Application	Filed	Yes

SERFF Tracking Number:	*UHLC-126575306*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*45371*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*MIPPA Web Enrollment Application/S93143AGWBAR01 01B*		

Form Schedule

Lead Form Number: S931436AGWBAR01 01B

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed 04/09/2010	S931436AGWBAR01 01B	Application/ Enrollment Form	WEB Enrollment Application	Initial		45.000	S93143AGWBAR01 01B.pdf

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

Required input fields are marked with an asterisk (*)

Welcome to the online enrollment program for the AARP Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company, Horsham, PA 19044. Please read all information on this page before beginning your application.

BEFORE GETTING STARTED

Before getting started, you will need to have the following information available during the enrollment process:

- **Medical history**, if applicable
- **Prior insurance coverage information**, if applicable

The estimated time required to complete the application process is approximately 35 minutes.

HERE'S HOW TO APPLY...

1. **Complete** the online enrollment application,
2. **Verify** the information you provided on the enrollment application,
3. **Submit** the online enrollment application, and
4. **Forward** any additional documentation identified during the application process that will be required to process your application.

If you have any questions during your online enrollment process, please utilize the **online Help Feature** located at the top right corner of each screen or **contact a Customer Service Representative** at **1-800-619-9827** between the hours of **7am-11pm EST Monday - Friday and 9am-5pm EST Saturday**.

Please mail or fax the additional documentation to:

UnitedHealthcare
P.O. Box 105331
Atlanta, GA 30348-5331

Fax Number: **888-836-3985**

FYI

If you do not complete the process and leave your computer idle for 30 minutes, you will be logged out of your application.

As you click the "Continue" and "Previous" buttons while you complete your application, your information will be saved. You can retrieve your saved application at any time by visiting the "Your Account" section of the AARP Health website.

You will not be required to pay for your insurance coverage at the time of the online enrollment; you will be billed later for your first month's premium.

If you are currently insured, you will be receiving updated information reflecting your new monthly rate.

Your coverage will become effective on the first day of the month following receipt and approval of your completed application, provided your first month's payment is received within 30 days from the effective date shown on your Certificate of Insurance.

Once your enrollment application is processed, we'll notify you by mail of:

- Your acceptance
- Your rate
- Your coverage start date

See the Benefit and Rate Chart for the rates.

S93143AGWBAR01 01B

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

▶ Save Application ▶ Exit
▶ Print Application ▶ Larger Text

STEPS 1 2 3 4 5 6 7 8 9 10 11 12

TELL US ABOUT YOURSELF

Questions?
Call UnitedHealthcare at 1-800-619-9827 (TTY: 711)
Hours: 8AM - 8PM in your time zone
? Help

Required input fields are marked with an asterisk (*)

AARP Membership Number:	014241666-1
Contact Information:	MR JTQFTZZT X SIMPSON 123 Main St. Boyertown, AZ 86038
Phone Number:	(215) 653-1212
E-mail Address:	
Birth Date:	1/11/1919
Gender:	F

Medicare Health Insurance

(Click here to view a sample Medicare Health Insurance card)

Medicare Claim Number:

(Please enter Medicare Claim Number without dashes or spaces)

Hospital (Part A) Effective Date: / 01 /
M M / D D / Y Y Y Y

Medical (Part B) Effective Date: 1/1/1984

* **Are both Medicare Parts A & B coverage active?** ○ Yes ○ No

Promotional Code: PROMO
(optional)

◀ PREVIOUS CONTINUE ▶

S93143AGWBAR01 01B

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

▶ Save Application ▶ Exit
▶ Print Application ▶ Larger Text

STEPS 1 2 3 4 5 6 7 8 9 10 11 12

SELECT THE AARP-ENDORSED PLAN THAT BEST MEETS YOUR NEEDS

Questions?
Call UnitedHealthcare at 1-800-619-9827 ? Help
(TTY: 711)
Hours: 8AM - 8PM in your time zone

Required input fields are marked with an asterisk (*)

*** I wish to apply for Plan (select one):**

AARP Medicare Supplement Plan	AARP Medicare Select
○ Medicare Supplement Plan A	○ AARP Medicare Select Plan C
○ Medicare Supplement Plan B	○ AARP Medicare Select Plan F
○ Medicare Supplement Plan C	
○ Medicare Supplement Plan D	
○ Medicare Supplement Plan F	
○ Medicare Supplement Plan G	
○ Medicare Supplement Plan K	
○ Medicare Supplement Plan L	
○ Medicare Supplement Plan M	
○ Medicare Supplement Plan N	

You are eligible to enroll if all of these are true:

- you are an AARP member,
- you are age 65 or older,
- you are enrolled in Medicare Parts A & B,
- you are not duplicating Medicare Supplement coverage.

Please refer to the Outline of Medicare Supplement Coverage - Cover Page for the monthly cost of the plan you have selected. **SEND NO MONEY NOW.** You will be billed later.

Your coverage will become effective on the first day of the month following receipt and approval of this application and first month's premium. You will receive a Certificate of Insurance confirming your effective date.
If you would like your coverage to begin at a later date (the 1st day of a future month), please indicate below.

Requested Effective Date: ___ / 01 / ____
M M / D D / Y Y Y Y
(first of the future month)

◄ PREVIOUS CONTINUE ►

S93143AGWBAR01 01B

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

▶ Save Application ▶ Exit
▶ Print Application ▶ Larger Text

Required input fields are marked with an asterisk (*)

a) * Did you turn age 65 in the last 6 months?
○ Yes ○ No

b) * Did you enroll in Medicare Part B within the last 6 months?
○ Yes ○ No

c) * Will your plan effective date be within 6 months after turning age 65 and enrolling in Medicare Part B?
○ Yes ○ No

If you answer "Yes" to any of the questions, your ACCEPTANCE IS GUARANTEED and you can SKIP THE NEXT THREE STEPS.

If you answered **NO to a, b, and c,** continue to question **d**.

d) Have you lost other health insurance coverage and, if so, are you an eligible person as defined within the termination notice you received from your prior insurer? If the answer is "Yes," you may be guaranteed acceptance in certain AARP Medicare Supplement Plans. A copy of the termination notice must be submitted to successfully process your application. SKIP THE NEXT THREE STEPS.
○ Yes ○ No

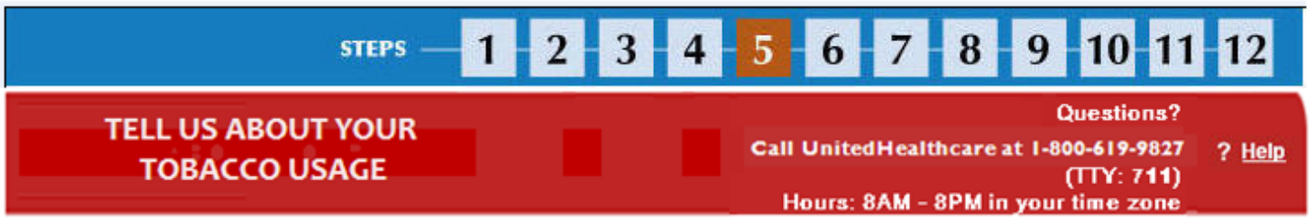
If you answered "No" to a, b, c and d above, GO TO THE NEXT STEP.

◀ PREVIOUS CONTINUE ▶

S93143AGWBAR01 01B

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

▶ Save Application ▶ Exit
▶ Print Application ▶ Larger Text



Required input fields are marked with an asterisk (*)

If you have smoked cigarettes or used any tobacco product at any time within the past twelve months, click this circle: ◯

◀ PREVIOUS CONTINUE ▶

S93143AGWBAR01 01B

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

▶ Save Application ▶ Exit
▶ Print Application ▶ Larger Text

Required input fields are marked with an asterisk (*)

If you answer "Yes" to either of the questions below and do not meet any of the Guaranteed Acceptance requirements in the previous step, you are NOT eligible for these plans at this time.

If your health status changes in the future, allowing you to answer NO to all of the questions in this step, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answer "No" to both questions below, GO TO THE NEXT STEP.

a) * **Do any of these apply to you?**
- **have end stage renal (kidney) disease**
- **currently receiving dialysis**
- **diagnosed with kidney disease that may require dialysis**
- **admitted to a hospital as an inpatient within the past 90 days**

○ Yes ○ No

b) * **Within the past two years, has a medical professional recommended or discussed as a treatment option, any of the following that has NOT been completed:**
- **hospital admittance as an inpatient**
- **organ transplant**
- **back or spine surgery**
- **joint replacement**
- **surgery for cancer**
- **heart surgery**
- **vascular surgery**

○ Yes ○ No

◀ PREVIOUS CONTINUE ▶

S93143AGWBAR01 01B

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

HEALTH HISTORY

Questions?
Call UnitedHealthcare at 1-800-619-9827 ? Help
(TTY: 711)
Hours: 8AM – 8PM in your time zone

Required input fields are marked with an asterisk (*)

COMPLETE THIS STEP only if you enrolled in Medicare Part B seven or more months ago.
All Others SKIP THIS STEP AND GO TO THE NEXT STEP.

If you click a box for any of the medical conditions in this Step (7), your rate will be the level 2 rate. Please see "Cover Page - Rates".

Read the conditions listed below carefully. If within the past two years, you have been diagnosed, treated, or had any of the following conditions, click the box next to it. If you are unsure how to respond, please consult your physician.

A. Heart or Vascular Conditions
- ☐ Aneurysm
- ☐ Arteriosclerosis or Atherosclerosis
- ☐ Artery or Vein Blockage
- ☐ Atrial Fibrillation or Atrial Flutter
- ☐ Cardiomyopathy
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure (CHF)
- ☐ Coronary Artery Disease (CAD)
- ☐ Heart Attack
- ☐ Peripheral Vascular Disease or Claudication
- ☐ Stroke, Transient Ischemic Attack (TIA), or mini-stroke
- ☐ Ventricular Tachycardia

B. Diabetes
- ☐ With any of the following complications:
  Circulatory problems, Kidney problems, or Retinopathy

C. Lung/Respiratory Conditions
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Emphysema

D. Cancer or Tumors
- ☐ Cancer (other than skin cancer)
- ☐ Leukemia or Lymphoma
- ☐ Melanoma

E. Kidney Conditions
- ☐ Chronic Renal Failure or Insufficiency
- ☐ Polycystic Kidney Disease
- ☐ Renal Artery Stenosis

F. Liver
- ☐ Cirrhosis of the Liver

G. Transplants
- ☐ Bone marrow or organ transplant

H. Gastrointestinal Conditions
- ☐ Chronic Pancreatitis
- ☐ Esophageal Varices

I. Musculoskeletal Conditions

- [ ] Amputation due to disease
- [ ] Rheumatoid Arthritis
- [ ] Spinal Stenosis

J. Substance Abuse

- [ ] Alcohol Abuse or Alcoholism
- [ ] Drug Abuse or use of illegal drugs

K. Brain or Spinal Cord Conditions

- [ ] Paraplegia, Quadriplegia, or Hemiplegia

L. Psychological/Mental Conditions

- [ ] Bipolar or Manic Depressive
- [ ] Schizophrenia

M. Eye Condition

- [ ] Macular Degeneration

N. Nervous System Conditions

- [ ] Amyotrophic Lateral Sclerosis (ALS)
- [ ] Alzheimer's Disease or Dementia
- [ ] Multiple Sclerosis (MS)
- [ ] Parkinson's Disease
- [ ] Systemic Lupus Erythematosus (SLE)

O. Immune System Conditions

- [ ] AIDS
- [ ] HIV positive

◄ PREVIOUS CONTINUE ►

S93143AGWBAR01 01B

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

▶ Save Application ▶ Exit
▶ Print Application ▶ Larger Text

STEPS 1 2 3 4 5 6 7 8 9 10 11 12

FOR YOUR PROTECTION YOU ARE REQUIRED TO ANSWER ALL THE FOLLOWING QUESTIONS AND SIGN WHERE INDICATED

Questions?
Call UnitedHealthcare at 1-800-619-9827
(TTY: 711)
Hours: 8AM - 8PM in your time zone
? Help

Required input fields are marked with an asterisk (*)

MR JTQFTZZT X SIMPSON
123 Main St.
Boyertown, UT 19501

Please review the statements below, and then answer all questions to the best of your knowledge.

- You do not need more than one Medicare supplement insurance policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

1a) Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare Program.) [NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question.]
If "Yes," continue. If "No," go to question number 2a

○ Yes ○ No

1b) Will Medicaid pay your premiums for this Medicare supplement policy?

○ Yes ○ No

1c) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

○ Yes ○ No

2a) Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

○ Yes ○ No

If NO, skip to question 3a.

2b) If YES, fill in your start and end dates and continue to question 2c. If you are still covered under this plan, leave "END" blank.

START: ___ / ___ / _____ (M M / D D / Y Y Y Y)

END: ___ / ___ / _____ (M M / D D / Y Y Y Y)

2c) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

○ Yes ○ No

2d) Was this your first time in this type of Medicare plan?

○ Yes ○ No

2e) Did you drop a Medicare supplement policy to enroll in the Medicare Plan?

○ Yes ○ No

3a) Do you have another Medicare supplement policy in force?

○ Yes ○ No

If NO, skip to question 4a.
If YES, please continue.

3b) If "Yes," do you intend to replace your current Medicare supplement policy with this policy?

○ Yes ○ No

4a) Have you had coverage under any other health insurance within the past 63 days? (For example, an HMO/PPO, major medical, employer, union, or individual plan.)

○ Yes ○ No

If NO, please CLICK the "I have read and agree to the above" box below and CONTINUE TO THE NEXT STEP.

4b) If "Yes," with what company and what type of policy?

Company: _____

Type of Policy: _____

4c) What are your dates of coverage under the policy you listed in 4b)? If you are still covered under this policy, leave "END" blank.

START: ___ / ___ / _____ (M M / D D / Y Y Y Y)

END: ___ / ___ / _____ (M M / D D / Y Y Y Y)

4d) Are you replacing this health insurance (as indicated in question 4b) ?

○ Yes ○ No

☐ * I have read and agree to the above.

◄ PREVIOUS CONTINUE ►

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

▶ Save Application ▶ Exit
▶ Print Application ▶ Larger Text

STEPS 1 2 3 4 5 6 7 8 9 10 11 12

PLEASE REVIEW YOUR INFORMATION

Questions?
Call UnitedHealthcare at 1-800-619-9827 (TTY: 711)
Hours: 8AM - 8PM in your time zone
? Help

Required input fields are marked with an asterisk (*)

CAREFULLY REVIEW YOUR ANSWERS BELOW

- Use the [edit] link next to each section title to go back and edit that section.
- When you are satisfied that you have answered all questions accurately, click "CONTINUE."

TELL US ABOUT YOURSELF [edit]

AARP Membership Number:	014241666-1
Contact Information:	MR JTQFTZZT X SIMPSON 123 Main St. Boyertown, UT 19501
Phone Number:	(215) 653-1212
E-mail Address:	
Birth Date:	1/11/1919
Gender:	F

Medicare Health Insurance

Medicare Claim Number:	
Hospital (Part A) Effective Date:	
Medical (Part B) Effective Date:	
* Are both Medicare Parts A & B coverage active?	Yes

Promotional Code:	PROMO

SELECT THE AARP-ENDORSED PLAN THAT BEST MEETS YOUR NEEDS [edit]

* I wish to apply for Plan (select one):

Medicare Supplement Plan F

- **You are eligible to apply if you are an AARP member, age 65 or older, enrolled in Medicare Parts A and B, and not duplicating Medicare Supplement coverage.**
- Please refer to the Outline of Medicare Supplement Coverage - Cover Page for the monthly cost of the plan you have selected. **SEND NO MONEY NOW.** You will be billed later.
- **Your coverage will become effective on the first day of the month following receipt and approval of your completed enrollment application and first month's payment, if applicable.** You will receive a Certificate of Insurance confirming your effective date. (**If you would like your coverage to begin at a later date,** please indicate below.)

Requested Effective Date:

YOUR ACCEPTANCE MAY BE GUARANTEED [edit]

a) * Did you turn age 65 in the last 6 months?
No

b) * Did you enroll in Medicare Part B within the last 6 months?
No

c) * Will your plan effective date be within 6 months after turning age 65 and enrolling in Medicare Part B?
No

If you answered "Yes" to any of the questions above, your ACCEPTANCE IS GUARANTEED and you can SKIP THE NEXT THREE STEPS.

If you answered NO to A, B, and C, **continue to question** D

d) Have you lost other health insurance coverage and, if so, are you an eligible person as defined within the termination notice you received from your prior insurer? If the answer is "Yes," you may be guaranteed acceptance in certain AARP Medicare Supplement Plans. A copy of the termination notice must be submitted to successfully process your application. SKIP THE NEXT THREE STEPS.
○ Yes ○ No

If you answered "No" to a, b, c and d above, GO TO THE NEXT STEP.

TELL US ABOUT YOUR TOBACCO USAGE

If you have smoked cigarettes or used any tobacco product at any time within the past twelve months, click this circle: ○

COVERAGE ELIGIBITY HEALTH QUESTIONS [edit]

If you answer "Yes" to either of the questions below and do not meet any of the Guaranteed Acceptance requirements in the previous step, you are NOT eligible for these plans at this time.

If your health status changes in the future, allowing you to answer NO to all of the questions in this step, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answer "No" to both questions below, GO TO THE NEXT STEP.

a) * Do any of these apply to you?
- have end stage renal (kidney) disease
- currently receiving dialysis
- diagnosed with kidney disease that may require dialysis
- admitted to a hospital as an inpatient within the past 90 days

No

b) * Within the past two years, has a medical professional recommended or discussed as a treatment option, any of the following that has NOT been completed:
- hospital admittance as an inpatient
- organ transplant
- back or spine surgery
- joint replacement
- surgery for cancer
- heart surgery
- vascular surgery

No

HEALTH HISTORY [edit]

COMPLETE THIS STEP only if you enrolled in Medicare Part B seven or more months ago.
All Others SKIP THIS STEP AND GO TO THE NEXT STEP.

If you click a box for any of the medical conditions in this Step (7), your rate will be the level 2 rate. Please see "Cover Page - Rates".

Read the conditions listed below carefully. If within the past two years, you have been diagnosed, treated, or had any of the following conditions, click the box next to it. If you are unsure how to respond, please consult your physician.

A. Heart or Vascular Conditions

- [ ] Aneurysm
- [ ] Arteriosclerosis or Atherosclerosis
- [ ] Artery or Vein Blockage
- [ ] Atrial Fibrillation or Atrial Flutter
- [ ] Cardiomyopathy
- [ ] Carotid Artery Disease
- [ ] Congestive Heart Failure (CHF)
- [ ] Coronary Artery Disease (CAD)
- [ ] Heart Attack
- [ ] Peripheral Vascular Disease or Claudication
- [ ] Stroke, Transient Ischemic Attack (TIA), or mini-stroke
- [ ] Ventricular Tachycardia

B. Diabetes

- [ ] With any of the following complications:
  Circulatory problems, Kidney problems, or Retinopathy

C. Lung/Respiratory Conditions

- [ ] Chronic Obstructive Pulmonary Disease (COPD)
- [ ] Emphysema

D. Cancer or Tumors

- [ ] Cancer (other than skin cancer)
- [ ] Leukemia or Lymphoma
- [ ] Melanoma

E. Kidney Conditions

- [ ] Chronic Renal Failure or Insufficiency
- [ ] Polycystic Kidney Disease
- [ ] Renal Artery Stenosis

F. Liver

- [ ] Cirrhosis of the Liver

G. Transplants

- [ ] Bone marrow or organ transplant

H. Gastrointestinal Conditions

- [ ] Chronic Pancreatitis
- [ ] Esophageal Varices

I. Musculoskeletal Conditions

- [ ] Amputation due to disease
- [ ] Rheumatoid Arthritis
- [ ] Spinal Stenosis

J. Substance Abuse

- [ ] Alcohol Abuse or Alcoholism
- [ ] Drug Abuse or use of illegal drugs

K. Brain or Spinal Cord Conditions

- [ ] Paraplegia, Quadriplegia, or Hemiplegia

L. Psychological/Mental Conditions

- [ ] Bipolar or Manic Depressive
- [ ] Schizophrenia

M. Eye Condition

- [ ] Macular Degeneration

N. Nervous System Conditions

- [ ] Amyotrophic Lateral Sclerosis (ALS)
- [ ] Alzheimer's Disease or Dementia
- [ ] Multiple Sclerosis (MS)
- [ ] Parkinson's Disease
- [ ] Systemic Lupus Erythematosus (SLE)

O. Immune System Conditions

- [ ] AIDS
- [ ] HIV positive

FOR YOUR PROTECTION YOU ARE REQUIRED TO ANSWER ALL THE FOLLOWING QUESTIONS AND SIGN WHERE INDICATED [edit]

MR JTQFTZZT X SIMPSON
123 Main St.
Boyertown, IA 19502

Please review the statements below, and then answer all questions to the best of your knowledge.

- You do not need more than one Medicare supplement insurance policy.
- You may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

1a) Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare Program.) [NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question.]
If "Yes," continue. If "No," go to question number 2a

○ Yes ○ No

1b) Will Medicaid pay your premiums for this Medicare supplement policy?

○ Yes ○ No

1c) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

○ Yes ○ No

2a) Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)?

○ Yes ○ No

If NO, skip to question 3a.

2b) If YES, fill in your start and end dates and continue to question 2c. If you are still covered under this plan, leave "END" blank.

START: ___ / ___ / _____ (M M / D D / Y Y Y Y)

END: ___ / ___ / _____ (M M / D D / Y Y Y Y)

2c) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

○ Yes ○ No

2d) Was this your first time in this type of Medicare plan?

○ Yes ○ No

2e) Did you drop a Medicare supplement policy to enroll in the Medicare Plan?

○ Yes ○ No

3a) Do you have another Medicare supplement policy in force?

○ Yes ○ No

If NO, skip to question 4a.
If YES, please continue.

3b) If "Yes," do you intend to replace your current Medicare supplement policy with this policy?

○ Yes ○ No

4a) Have you had coverage under any other health insurance within the past 63 days? (For example, an HMO/PPO, major medical, employer, union, or individual plan.)

○ Yes ○ No

If NO, please CLICK the "I have read and agree to the above" box below and CONTINUE TO THE NEXT STEP.

4b) If "Yes," with what company and what type of policy?

Company: _____

Type of Policy: _____

4c) What are your dates of coverage under the policy you listed in 4b)? If you are still covered under this policy, leave "END" blank.

START: ___ / ___ / _____ (M M / D D / Y Y Y Y)

END: ___ / ___ / _____ (M M / D D / Y Y Y Y)

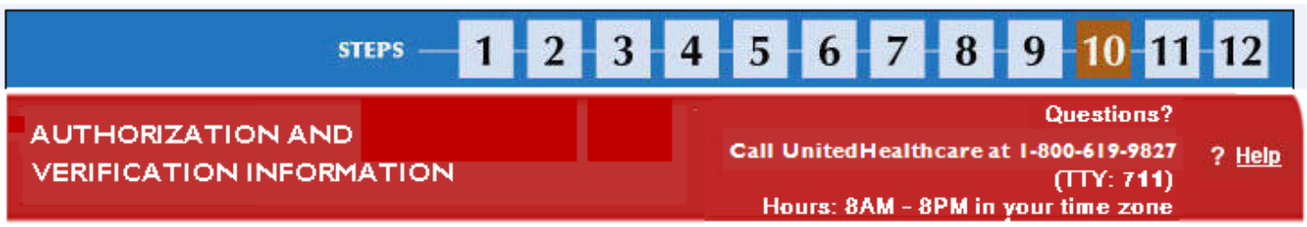
4d) Are you replacing this health insurance (as indicated in question 4b) ?

○ Yes ○ No

√ * I have read and agree to the above.

◄ PREVIOUS CONTINUE ►

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044



Required input fields are marked with an asterisk (*)

Please read carefully, and sign and date in the highlighted area below.

- My electronic signature below indicates I have read and understand the contents of this application form.
- I declare the answers on this application form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this application form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, UnitedHealthcare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I understand an agent or broker cannot grant approval. This application and payment of the initial premium does not guarantee coverage will be provided. I understand coverage, if provided, will not take effect until issued by UnitedHealthcare Insurance Company, and actual rates are not determined until coverage is issued.
- I understand an agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.
- If you are enrolling in a Medicare Select Plan: I acknowledge that I have received an Outline of Coverage, Grievance Procedure, Provider Directory, and a Medicare Select Disclosure Statement covering Provider Restrictions, Right to Replace Your Medicare Supplement Plan and Quality Assurance Program. I affirm that I understand the benefits, restrictions, limitations and other provisions of the Medicare Select Plan for which I am applying.
- I acknowledge that I have reviewed the Outline of Coverage.
- I understand that an agent discussing plan options with me is appointed by UnitedHealthcare Insurance Company and may be compensated based on my enrollment in a plan.

Authorization for the Release of Medical Information

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine my eligibility for coverage and rate. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in the health plan or to receive benefits, if permitted by law. I understand the information I authorize The Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand that I may end this authorization if I notify The Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. This authorization is valid for 24 months from the date of my signature.

Please see “Your Guide” to determine if the following pre-existing condition waiting period applies to you.

I understand the plan will not pay benefits for stays beginning, or medical expenses incurred, during the first 3 months of coverage if they are due to conditions for which medical advice was given, or treatment recommended by, or received from, a physician within 3 months prior to the insurance effective date.

Note: If you are signing as the legal representative of the applicant, please submit a copy of the appropriate legal documentation.

☐ * I have read and agree to the above.

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give UnitedHealthcare Insurance Company and its affiliates ("The Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow The Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand that I may end this authorization if I notify The Company, in writing, except to the extent that The Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

Note: If you are signing as the legal representative of the applicant, please submit a copy of the appropriate legal documentation.

☐ * I have read and agree to the above.

Plan Rates

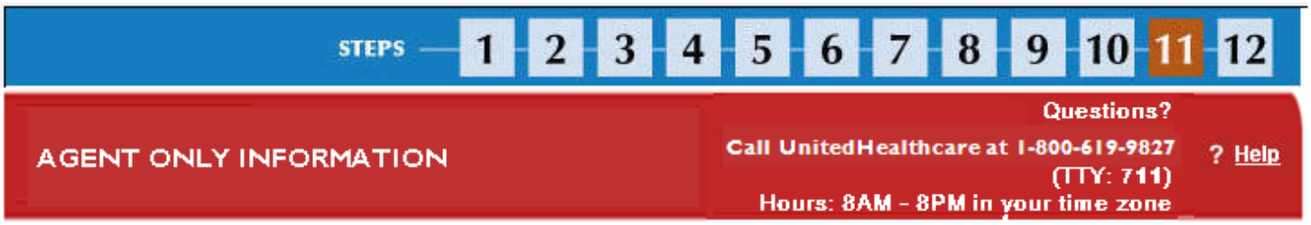
Please refer to the "Cover Page- Rates" for the monthly cost of the plan you have selected. If you answered YES to any medical conditions in Step 7, your rate will be the level 2 rate. Once your application is processed, you'll be notified of your acceptance, rate and insurance start date.

Send No Money Now. You will receive updated payment instructions later.

S93143AGWBAR01 01B

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

▶ Save Application ▶ Exit
▶ Print Application ▶ Larger Text



Required input fields are marked with an asterisk (*)

If application is being made through an agent, he or she must complete the following; and if appropriate, the notice of replacement coverage included with this application. All information must be completed or the application will be returned.

List any other medical or health insurance policies sold to the applicant:

List any policies that are still in force:

List policies sold in the past five years that are no longer in force:

Agent Name:

Agent Phone Number:

Agent ID:

☐ * **Agent: I have read and agree to the above.**

◄ PREVIOUS CONTINUE ►

S93143AGWBAR01 01B

APPLICATION FORM
AARP Medicare Supplement Insurance Plans
Insured by UnitedHealthcare Insurance Company
Horsham, PA 19044

NOTICE TO APPLICANTS

Questions?
Call UnitedHealthcare at 1-800-619-9827
(TTY: 711)
Hours: 8AM – 8PM in your time zone
? Help

Required input fields are marked with an asterisk (*)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVATANGE

UnitedHealthcare Insurance Company,
Horsham, Pennsylvania

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to the information you furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by UnitedHealthcare Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you may desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement policy or leave your Medicare Advantage plan. The replacement policy is being purchased for one of the following reasons:

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
- ☐ Other. Please specify. **test**

1. Health conditions which you may presently have (Pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

☐ * **I have read and agree to the above (Agent, Broker or Other Representative)**

☐ * **I have read and agree to the above (Applicant)**

PREVIOUS

Submit Application

SERFF Tracking Number:	*UHLC-126575306*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare Insurance Company*	*State Tracking Number:*	*45371*
Company Tracking Number:	*S931436AGWBAR01 01B*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*MIPPA Web Enrollment Application/S93143AGWBAR01 01B*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Filed	04/09/2010

Comments:

Attachment:

READABILITY CERTIFICATION FORM.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Filed	04/09/2010

Comments:

please see form schedule tab to review enrollment application, thanks

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		

Bypass Reason: n/a

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		

Bypass Reason: n/a

Comments:

UNITED HEALTHCARE INSURANCE COMPANY
READABILITY CERTIFICATION

THIS IS TO CERTIFY THAT THE FOLLOWING FORM(S) HAVE ACHIEVED A FLESCH READING EASE TEST SCORE OF:

FORM NUMBER	FLESCH SCORE
S931436AGWBAR01 01B	45

SIGNATURE

Paul Kallmeyer, Assistant Secretary, UHIC
NAME AND TITLE

April 7, 2010
DATE